FOR OHF USE

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046201

Facility Name: Lemont Nursing & Rehab Center, Llc

Address: 12450 Walker Road (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

IDPA ID Number: 383663760001

Date of Initial License for Current Owners: 02/01/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 6/8/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	158	51,756	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	158	51,756	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,047	13,412	12,379	41,838	8
9	SNF/PED					9
10	ICF	2,469	2,063	12	4,544	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,516	15,475	12,391	46,382	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.62%

D. How many bed-hold days during this year were paid by Public Aid? 51 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 130 and days of care provided 12,301

Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	253,637	40,458	11,924	306,019		306,019	(901)	305,118			1
2	Food Purchase		193,757		193,757		193,757	(308)	193,449			2
3	Housekeeping	123,958	32,288		156,246		156,246	(2,559)	153,687			3
4	Laundry	41,373	19,244		60,617		60,617	(10,785)	49,832			4
5	Heat and Other Utilities			127,171	127,171		127,171	1,215	128,386			5
6	Maintenance	114,811		94,696	209,507		209,507	1,768	211,275			6
7	Other (specify):*							1,226	1,226			7
8	**TOTAL General Services**	533,779	285,747	233,791	1,053,317		1,053,317	(10,345)	1,042,972			8
	B. Health Care and Programs											
9	Medical Director			13,750	13,750		13,750		13,750			9
10	Nursing and Medical Records	2,818,594	148,779	223,806	3,191,179		3,191,179	(2,716)	3,188,463			10
10a	Therapy	148,155	6,589		154,744		154,744	411	155,155			10a
11	Activities	151,337	31,739	2,136	185,212		185,212	22	185,234			11
12	Social Services	112,844		4,811	117,655		117,655	7,359	125,014			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,894	3,894			15
16	**TOTAL Health Care and Programs**	3,230,930	187,107	244,503	3,662,540		3,662,540	8,970	3,671,510			16
	C. General Administration											
17	Administrative	69,863			69,863		69,863	8,924	78,787			17
18	Directors Fees											18
19	Professional Services			215,689	215,689		215,689	(123,104)	92,585			19
20	Dues, Fees, Subscriptions & Promotions			21,987	21,987		21,987	(6,309)	15,678			20
21	Clerical & General Office Expenses	106,446	28,332	140,569	275,347		275,347	30,620	305,967			21
22	Employee Benefits & Payroll Taxes			624,088	624,088		624,088	(6,877)	617,211			22
23	Inservice Training & Education			1,078	1,078		1,078		1,078			23
24	Travel and Seminar			1,217	1,217		1,217	765	1,982			24
25	Other Admin. Staff Transportation			1,265	1,265		1,265		1,265			25
26	Insurance-Prop.Liab.Malpractice			128,142	128,142		128,142	1,005	129,147			26
27	Other (specify):*							13,789	13,789			27
28	**TOTAL General Administration**	176,309	28,332	1,134,035	1,338,676		1,338,676	(81,187)	1,257,489			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,941,018	501,186	1,612,329	6,054,533		6,054,533	(82,562)	5,971,971			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc #0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,299	12,299		12,299	112,148	124,447			30
31	Amortization of Pre-Op. & Org.			1,588	1,588		1,588	3,144	4,732			31
32	Interest			26,767	26,767		26,767	181,849	208,616			32
33	Real Estate Taxes			258,161	258,161		258,161	(48,356)	209,805			33
34	Rent-Facility & Grounds			423,160	423,160		423,160	(420,173)	2,987			34
35	Rent-Equipment & Vehicles			22,235	22,235		22,235	1,448	23,683			35
36	Other (specify):*											36
37	**TOTAL Ownership**			744,210	744,210		744,210	(169,940)	574,270			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		452,158	785,449	1,237,607		1,237,607	(8,178)	1,229,429			39
40	Barber and Beauty Shops			29,561	29,561		29,561	(29,561)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,200	79,200		79,200	(1,566)	77,634			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		452,158	894,210	1,346,368		1,346,368	(39,305)	1,307,063			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,941,018	953,344	3,250,749	8,145,111		8,145,111	(291,807)	7,853,304			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(959)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,087)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(636)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,200)	21		24
25	Fund Raising, Advertising and Promotional	(6,862)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(264)	20		28
29	Other-Attach Schedule	(113,110)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (198,119)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(93,688)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (93,688)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (291,807)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 02/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (34)	10	1
2	Barber & Beauty	(29,561)	40	2
3	Bank Charges	(2,327)	21	3
4	Theft Loss	(120)	21	4
5	Misc. Income	(65)	21	5
6	IHCA PAC Dues	(120)	20	6
7	Bldg Co. - Bank Charges	(675)	21	7
8	Bldg Co. - Amortization of Goodwill	(74,767)	31	8
9	Excess Bed Tax	(1,566)	42	9
10	Non-allowable Legal	(1,581)	19	10
11	Capitalized R&M	(2,294)	6	11
12				12
13				13
14				14
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100				100
101	**Total**	(113,110)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			40		2,652	(1,905)		(1,688)				(901)	1
2	Food Purchase	(1,595)		(71)			1,390		(32)				(308)	2
3	Housekeeping					762			(3,321)				(2,559)	3
4	Laundry								(10,785)				(10,785)	4
5	Heat and Other Utilities			1,215									1,215	5
6	Maintenance	(2,294)		1,268	36	2,788	3		(33)				1,768	6
7	Other (specify):*				365	769	92						1,226	7
8	**TOTAL General Services**	(3,889)		2,452	401	6,971	(420)		(15,860)				(10,345)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)		160	(6,369)	8,805			(5,278)				(2,716)	10
10a	Therapy					411							411	10a
11	Activities			22									22	11
12	Social Services				7,236	123							7,359	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				2,758	1,136							3,894	15
16	**TOTAL Health Care and Programs**	(34)		182	3,625	10,475			(5,278)				8,970	16
	C. General Administration													
17	Administrative					8,858	66						8,924	17
18	Directors Fees													18
19	Professional Services	(1,581)		(121,545)			22						(123,104)	19
20	Fees, Subscriptions & Promotions	(7,246)		931			6						(6,309)	20
21	Clerical & General Office Expenses	(71,387)	675	13,513	(200)	87,878	141						30,620	21
22	Employee Benefits & Payroll Taxes				(5,753)			(941)	(183)				(6,877)	22
23	Inservice Training & Education													23
24	Travel and Seminar			584			181						765	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			1,005									1,005	26
27	Other (specify):*				1,836	11,953							13,789	27
28	**TOTAL General Administration**	(80,214)	675	(105,512)	(4,117)	108,689	416	(941)	(183)				(81,187)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,137)	675	(102,878)	(91)	126,135	(4)	(941)	(21,321)				(82,562)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 **Report Period Beginning:** 02/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(8,087)	113,765	6,470									112,148	30
31	Amortization of Pre-Op. & Org.	(74,767)	77,911										3,144	31
32	Interest	(1)	169,114	12,734			2						181,849	32
33	Real Estate Taxes		(50,161)	1,805									(48,356)	33
34	Rent-Facility & Grounds		(423,160)	2,987									(420,173)	34
35	Rent-Equipment & Vehicles			1,413			35						1,448	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(82,855)	(112,531)	25,409			37						(169,940)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,331)		(6,847)				(8,178)	39
40	Barber and Beauty Shops	(29,561)											(29,561)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(1,566)											(1,566)	42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(31,127)					(1,331)		(6,847)				(39,305)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(198,119)	(111,856)	(77,469)	(91)	126,135	(1,298)	(941)	(28,168)				(291,807)	45

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached		see attached		see attached		
				Lemont Property LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 423,160	Lemont Building LLC		$	$ (423,160)	1
2	V	33	Real Estate Tax	258,163			208,002	(50,161)	2
3	V	32	Interest				169,114	169,114	3
4	V	30	Depreciation				113,765	113,765	4
5	V	31	Amortization				77,911	77,911	5
6	V	21	Bank Charges				675	675	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 681,323			$ 569,467	$ * (111,856)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 40	$ 40	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,215	1,215	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,268	1,268	17
18	V	10	Nursing	24	Care Centers, Inc.	100.00%	184	160	18
19	V	11	Activities		Care Centers, Inc.	100.00%	22	22	19
20	V	19	Professional Fees	129,668	Care Centers, Inc.	100.00%	8,123	(121,545)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	931	931	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	13,513	13,513	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	584	584	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,005	1,005	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	6,470	6,470	25
26	V	32	Interest		Care Centers, Inc.	100.00%	12,734	12,734	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,805	1,805	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,987	2,987	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,413	1,413	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food	71	Care Centers, Inc.	100.00%		(71)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 129,763			$ 52,294	$ * (77,469)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 2,830	Care Centers, Inc.	100.00%	$ 2,866	$ 36	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	365	365	16
17	V	10	Nursing Salary	16,594	Care Centers, Inc.	100.00%	10,225	(6,369)	17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	4,811	Care Centers, Inc.	100.00%	12,047	7,236	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,758	2,758	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	14,121	Care Centers, Inc.	100.00%	13,921	(200)	23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,836	1,836	24
25	V	22	Employee Benefits	5,753	Care Centers, Inc.	100.00%		(5,753)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,109			$ 44,018	$ * (91)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 2,652	$ 2,652	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%	762	762	16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,788	2,788	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	769	769	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	8,805	8,805	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	411	411	20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	123	123	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,136	1,136	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	8,858	8,858	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	87,878	87,878	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	11,953	11,953	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 126,135	$ * 126,135	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 2,980	Care Centers, Inc. - Health Systems Division	100.00%	$ 366	$ (2,614)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	1,390	1,390	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	3	3	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	66	66	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	22	22	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	6	6	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	141	141	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	181	181	22
23	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	2	2	23
24	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	35	35	24
25	V	39	Ancillary Enteral Supplies	2,495	Care Centers, Inc. - Health Systems Division	100.00%	1,164	(1,331)	25
26	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	709	709	26
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	92	92	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,475			$ 4,177	$ * (1,298)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 223,061	$ 223,061	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	224,002	CCS EMPLOYEE BENEFIT GROUP	100.00%		(224,002)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 224,002			$ 223,061	$ * (941)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 12,828	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 11,139	$ (1,688)	15
16	V	02	FOOD	243	XCEL MEDICAL SUPPLY, LLC	100.00%	211	(32)	16
17	V	03	HOUSEKEEPING	25,233	XCEL MEDICAL SUPPLY, LLC	100.00%	21,911	(3,321)	17
18	V	04	LAUNDRY	81,937	XCEL MEDICAL SUPPLY, LLC	100.00%	71,152	(10,785)	18
19	V	06	REPAIRS & MAINTENANCE	249	XCEL MEDICAL SUPPLY, LLC	100.00%	216	(33)	19
20	V	10	NURSING	40,100	XCEL MEDICAL SUPPLY, LLC	100.00%	34,821	(5,278)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	1,387	XCEL MEDICAL SUPPLY, LLC	100.00%	1,205	(183)	24
25	V	39	ANCILLARY	52,019	XCEL MEDICAL SUPPLY, LLC	100.00%	45,171	(6,847)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 213,996			$ 185,828	$ * (28,168)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.99	1.80%		$		1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	1.15	2.88%	CCS-VEBA	893	22-7	2
3	Mark Steinberg	Relative	Administrative	0	See Attached	1.55	3.07%	CCI-Salary	1,229	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,122		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,764,895	42	$ 1,527	$	46,382	$ 40	1
2	05	Utilities	Patient Days	1,764,895	42	46,229		46,382	1,215	2
3	06	Maintenance	Patient Days	1,764,895	42	48,251		46,382	1,268	3
4	10	Nursing	Patient Days	1,764,895	42	7,018		46,382	184	4
5	11	Activities	Patient Days	1,764,895	42	838		46,382	22	5
6	19	Professional Fees	Patient Days	1,764,895	42	309,074		46,382	8,123	6
7	20	Dues and Subscriptions	Patient Days	1,764,895	42	35,428		46,382	931	7
8	21	Office & Clerical	Patient Days	1,764,895	42	523,091		46,382	13,513	8
9	24	Travel and Seminar	Patient Days	1,764,895	42	22,233		46,382	584	9
10	26	Insurance	Patient Days	1,764,895	42	38,230		46,382	1,005	10
11	30	Depreciation	Patient Days	1,764,895	42	246,194		46,382	6,470	11
12	32	Interest	Patient Days	1,764,895	42	484,531		46,382	12,734	12
13	33	Real Estate Taxes	Patient Days	1,764,895	42	68,681		46,382	1,805	13
14	34	Rent - Building	Patient Days	1,764,895	42	113,677		46,382	2,987	14
15	35	Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		46,382	1,413	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,998,780	$		$ 52,294	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			213,393	213,393		2,866	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			26,918			365	2
3	10	Nursing Salary	Direct Cost			976,718	976,718		10,225	3
4	10a	Rehab Salary	Direct Cost			103,898	103,898			4
5	11	Activity Salary	Direct Cost			10,902	10,902			5
6	12	Social Service Salary	Direct Cost			306,863	306,863		12,047	6
7	15	Emp. Ben. - Healthcare	Direct Cost			174,348			2,758	7
8	17	Administration Salary	Direct Cost			1,191,200	1,191,200			8
9	21	Office Salary	Direct Cost			698,886	698,886		13,921	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			238,998			1,836	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,942,124	$ 3,501,860		$ 44,018	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	46,382	2,652	1
2	03	Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	46,382	762	2
3	06	Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	46,382	2,788	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		46,382	769	4
5	10	Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	46,382	8,805	5
6	10a	Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	46,382	411	6
7	12	Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	46,382	123	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		46,382	1,136	8
9	17	Administration Salary	Patient Days	1,764,895	42	337,043	337,043	46,382	8,858	9
10	21	Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	46,382	87,878	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		46,382	11,953	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,799,547	$ 4,272,235		$ 126,135	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,073,579		138,556		5,474	366	1
2	02	Food	Billable Income	2,073,579		852,614		5,474	1,390	2
3	06	Maintenance	Billable Income	2,073,579		1,311		5,474	3	3
4	17	Administration	Billable Income	2,073,579		25,000		5,474	66	4
5	19	Professional Fees	Billable Income	2,073,579		8,170		5,474	22	5
6	20	Dues & Subscriptions	Billable Income	2,073,579		2,312		5,474	6	6
7	21	Office & Clerical	Billable Income	2,073,579		53,285		5,474	141	7
8	24	Travel & Seminar	Billable Income	2,073,579		68,680		5,474	181	8
9	32	Interest Expense	Billable Income	2,073,579		571		5,474	2	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579		13,336		5,474	35	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		5,474	1,164	11
12	01	Dietary - Salary	Billable Income	2,073,579		268,554	268,554	5,474	709	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		5,474	92	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,582,287	$ 268,554		$ 4,177	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 223,061	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 223,061	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 11,139	1
2	02	FOOD	Direct Allocation						211	2
3	03	HOUSEKEEPING	Direct Allocation						21,911	3
4	04	LAUNDRY	Direct Allocation						71,152	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						216	5
6	10	NURSING	Direct Allocation						34,821	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						1,205	10
11	39	ANCILLARY	Direct Allocation						45,171	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 185,828	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage			$	$ 4,794,741			$ 169,114	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	LaSalle Bank		X	Line of Credit				31,071			26,767	6
7	Care Centers Allocation										12,736	7
8	See Supplemental Schedule							1,257,756				8
9	TOTAL Facility Related						$	$ 6,083,568			$ 208,617	9
	B. Non-Facility Related*											
10												10
11	Interest Income										(1)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1)	14
15	TOTALS (line 9+line14)						$	$ 6,083,568			$ 208,616	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Genesis (prior owners)		X				$	$ 328,185			$	8
9	Shareholder	X						929,571				9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							1,257,756				14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 02/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	(48,356)	2
3. Under or (over) accrual (line 2 minus line 1).	$	(48,356)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	258,163	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	209,807	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	248,291	8
	1999	266,255	9
	2000	268,724	10
	2001	273,267	11
	2002	245,866	12

2003 Accrual = 2002 Tax $245,869 x 1.05 = $258,163

Care Centers (Allocation) = $1,805

The credit on line 2 represents a credit from the prior owners for January 03 of $50,161 less CCI allocation of $1,805

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attached	Home Office Allocation	$ 68,681.49	$ 1,804.97
2.	22-27-300-048-0000	Long Term Care Property	$ 245,866.43	$ 245,866.43
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 314,547.92	$ 247,671.40

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 116,479
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 4,732
4. Dates Incurred: 2003

Nature of Costs: Organization Costs, Loan Closing Costs, Settlement Charges
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 823,094	1
2	Allocation from 2201 Main LLC			13,361	2
3	TOTALS			$ 836,455	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,167,965	95,516		95,516		95,516	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		50,538	1,689		1,689		1,799	68
69	Financial Statement Depreciation			12,300			(12,300)		69
70	TOTAL (lines 4 thru 69)		$ 4,218,503	$ 109,505		$ 97,205	$ (12,300)	$ 97,315	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,218,503	$ 109,505		$ 97,205	$ (12,300)	$ 97,315	1
2	Avary	2003	4,987		20	229	229	229	2
3	Cooler Repair	2003	522		20	24	24	24	3
4	Air Conditioner Repair	2003	985		20	45	45	45	4
5	Sewer Rodding	2003	725		20	24	24	24	5
6	Sewer Maintenance	2003	640		20	21	21	21	6
7	Floor Tile Replacement	2003	508		20	15	15	15	7
8	Lunchroom Door Repair	2003	852		20	25	25	25	8
9	Parking Lot Light Repairs	2003	1,290		20	38	38	38	9
10	Keypad Alarm	2003	547		20	14	14	14	10
11	Hot Water Repair	2003	950		20	20	20	20	11
12	Walk In Cooler - Compressor Repair	2003	1,450		20	30	30	30	12
13	Light Pole Repairs	2003	2,959		20	62	62	62	13
14	Light Pole Repairs	2003	1,090		20	23	23	23	14
15	Generator Repair	2003	859		20	14	14	14	15
16	Check Hot Water System	2003	937		20	16	16	16	16
17	State Required Backflow Test	2003	930		20	16	16	16	17
18	Insurance Proceeds	2003	(1,050)		20	(18)	(18)	(18)	18
19	Door Keypads & Sounder Install	2003	2,226		20	37	37	37	19
20	Toilet Bowls With Accessories	2003	631		20	8	8	8	20
21	Water Heater Repair	2003	504		20	6	6	6	21
22	Electrical Work	2003	2,545		20	32	32	32	22
23	Electrical Vestibule Doors	2003	7,060		20	88	88	88	23
24	Flash To Field Or Wall Flashings	2003	800		20	10	10	10	24
25	Keypads & Doorsite Sounders	2003	6,679		20	83	83	83	25
26	Deposit On Above	2003	(2,226)		20	(28)	(28)	(28)	26
27	Speakman Valve Group	2003	710		20	6	6	6	27
28	Roton Hinge	2003	609		20	5	5	5	28
29	Rewire Feeds For Ceiling Lights	2003	630		20	5	5	5	29
30	Service On Fire Alarm Control Panel	2003	1,234		20	10	10	10	30
31	Install Softener System	2003	2,946		20	25	25	25	31
32	Adjust Rooms With Hot Water Problem	2003	930		20	8	8	8	32
33	2Nd Floor Dining Room Heat Problem	2003	653		20	5	5	5	33
34	TOTAL (lines 1 thru 33)		$ 4,263,615	$ 109,505		$ 98,103	$ (11,402)	$ 98,213	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,263,615	$ 109,505		$ 98,103	$ (11,402)	$ 98,213	1
2	Replace Pipe	2003	633		20	5	5	5	2
3	Repair 4 Mainonnorthdrysystem"	2003	625		20	5	5	5	3
4	Fire Alarm Repair	2003	966		20	40	40	40	4
5	Fire Alarm Pipe	2003	820		20	31	31	31	5
6	Fire Alarm Conrol Panel	2003	508		20	17	17	17	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,267,167	$ 109,505		$ 98,201	$ (11,304)	$ 98,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	158		2003		$ 4,167,965	$ 95,516		$ 95,516	$	$ 95,516	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,167,965	$ 95,516		$ 95,516	$	$ 95,516	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC			2002	$ 18,412	$ 460		$ 460	$	$ 499	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from 2201 Main LLC			2002	17,048	852		852		923	9
10	Allocation from 2201 Main LLC			2003	15,078	377		377		377	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 50,538	$ 1,689		$ 1,689	$	$ 1,799	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 34,306	$ 2,492	$ 2,492	$	10	$ 28,365	71
72	Current Year Purchases	241,754	18,468	21,685	3,217	10	21,685	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 276,060	$ 20,960	$ 24,177	$ 3,217		$ 50,050	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers allocation			$ 17,704	$ 1,925	$ 1,925	$	5	$ 1,925	76
77	Care Centers allocation			1,442	144	144		5	144	77
78										78
79										79
80	TOTALS			$ 19,146	$ 2,069	$ 2,069	$		$ 2,069	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,398,828	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,534	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 124,447	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,087)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 150,430	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Care Centers Allocation				2,987			5
6								6
7	TOTAL				$ 2,987 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 23,683 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 38,142	$		$ 38,142	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,574			17,574	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			729,733			729,733	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				338,073		338,073	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						114,085		114,085	13
14	TOTAL			$		$ 785,449	$ 452,158		$ 1,237,607	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,086	$ 22,863	1
2	Cash-Patient Deposits	16,825	16,825	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,853,255	1,874,672	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,575	32,575	6
7	Other Prepaid Expenses	60,695	60,695	7
8	Accounts Receivable (owners or related parties)	290,458	4,883	8
9	Other(specify): See Attached Schedule	75,000	157,653	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,330,894	$ 2,170,166	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		4,167,965	14
15	Leasehold Improvements, at Historical Cost	26,627	26,627	15
16	Equipment, at Historical Cost	58,822	257,905	16
17	Accumulated Depreciation (book methods)	(12,299)	(12,299)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,223,456	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	12,026	114,891	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 85,176	$ 6,601,639	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,416,070	$ 8,771,805	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 446,566	$ 446,567	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,325	16,325	28
29	Short-Term Notes Payable	31,071	1,288,827	29
30	Accrued Salaries Payable	347,569	347,569	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,913	27,913	31
32	Accrued Real Estate Taxes(Sch.IX-B)	258,163	258,163	32
33	Accrued Interest Payable		(53)	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,340	20,340	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	130,474	130,474	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,278,421	$ 2,536,125	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,794,741	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,794,741	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,278,421	$ 7,330,866	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,137,649	$ 1,440,939	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,416,070	$ 8,771,805	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,287,649	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(150,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,137,649	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,137,649	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,053,333	1
2	Discounts and Allowances for all Levels	(3,815,293)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,238,040	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,531,846	6
7	Oxygen	900	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,532,746	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	33,245	13
14	Non-Patient Meals	959	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	343,133	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73,686	19
20	Radiology and X-Ray	25,140	20
21	Other Medical Services	181,610	21
22	Laundry	4,101	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 661,874	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	99	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 99	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,432,760	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,053,317	31
32	Health Care	3,662,540	32
33	General Administration	1,338,676	33
	B. Capital Expense		
34	Ownership	744,210	34
	C. Ancillary Expense		
35	Special Cost Centers	1,267,168	35
36	Provider Participation Fee	79,200	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,145,111	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,287,649	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,287,649	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,850	1,973	$ 61,692	$ 31.27	1
2	Assistant Director of Nursing	1,109	1,328	37,423	28.18	2
3	Registered Nurses	28,670	32,254	877,934	27.22	3
4	Licensed Practical Nurses	20,793	23,489	515,091	21.93	4
5	Nurse Aides & Orderlies	97,730	109,220	1,293,369	11.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,404	9,950	148,155	14.89	8
9	Activity Director	3,505	3,906	68,122	17.44	9
10	Activity Assistants	7,981	8,819	83,215	9.44	10
11	Social Service Workers	6,155	6,722	112,844	16.79	11
12	Dietician	855	905	13,263	14.66	12
13	Food Service Supervisor	1,778	2,037	39,427	19.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,749	21,711	200,947	9.26	15
16	Dishwashers					16
17	Maintenance Workers	6,317	6,946	114,811	16.53	17
18	Housekeepers	13,668	15,170	123,958	8.17	18
19	Laundry	4,842	5,160	41,373	8.02	19
20	Administrator	1,830	1,909	69,863	36.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,080	7,696	106,446	13.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,412	2,805	33,085	11.80	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	234,728	262,000	$ 3,941,018 *	$ 15.04	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	261	$ 11,924	01-03	35
36	Medical Director	monthly	13,750	09-03	36
37	Medical Records Consultant	monthly	1,332	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,510	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,136	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	CCI - see attached		21,405		48
49	TOTAL (lines 35 - 48)	306	$ 54,057		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,808	$ 148,846	10-03	50
51	Licensed Practical Nurses	1,238	49,604	10-03	51
52	Nurse Aides	162	3,920	10-03	52
53	TOTAL (lines 50 - 52)	4,208	$ 202,370		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Guajardo	Administrator	0	$ 69,863
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,863

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 16,975
Meyer Magence	Legal	50
CT Corporation	Legal (adjusted page 5)	446
Neal, Gerber & Eisen	Legal	54,292
Arnstein & Lehr	Legal	41
Winston & Strawn	Legal (adjusted page 5)	1,135
National Datacare	Data Processing	584
Sitebuilders	Data Processing	11
ADP	Payroll Processing	8,493
Achieve Health	Data Processing	2,800
TBT Enterprises	Unemployment Consult.	1,194
See Supplemetal Schedule		129,668
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 215,689

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 158,693
Unemployment Compensation Insurance	69,948
FICA Taxes	282,346
Employee Health Insurance	97,926
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Christmas Expense	1,790
Employee Physical	2,527
Misc. Employee Welfare	3,981
TOTAL (agree to Schedule V, line 22, col.8)	$ 617,211

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 449
Advertising: Employee Recruitment	7,061
Health Care Worker Background Check	
(Indicate # of checks performed 73)	1,571
Dues & Subscriptions	4,685
Licenses & Fees	975
Advertising & Promotion	6,862
Yellow Page Advertising	264
Allocation from Care Centers	937
Less: Public Relations Expense	( )
Non-allowable advertising	(6,862)
Yellow page advertising	(264)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,678

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,217
Allocation from Care Centers	765
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,982

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 02/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 02/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $1889**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,810** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **77,634**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **959**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.